Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MIDLAND MEMORIAL HOSPITAL
3255 W. PIONEER PKWY
ARLINGTON, TX 76013

Respondent Name
TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M4-12-2598-01

MFDR Date Received
April 10, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Since TDI moved to a 200% of MAR for outpatient services on 3/1/08 for hospital claims, we have reviewed the Medicare allowance and decided the insurance reimbursement does not meet this criteria. Medicare would have allowed this facility $4,195.31 per the OUTLIER calculations. The calculations are as follows: Based on their payment of $2,239.17, a supplemental payment is due."

Amount in Dispute: $1,956.14

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual Claim 99M0000657917 is in the Texas Star Network."

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Hwy 290, Austin, TX 78723, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 5, 2011	Outpatient Services	$1,956.14	$ 0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. Texas Insurance Code Chapter 1305 set outs the procedures for Workers' Compensation Health Care Networks.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated September 9, 2011

- CAC-31 – Claim specific negotiated discount.
- 356 – This outpatient allowance was based on the medicare's methodology (Part B) plus the Texas markup.
- 370 – This hospital outpatient allowance was calculated according to the APC rate. Plus markup.
- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service.
- 619 – The procedure/supply was not sufficiently indentified and/or quantified.
- 630 – This service is packaged with other services performed on the same date and reimbursement is based on a single composite APC rate.
- 728 – This bill was reviewed/denied in accordance with your First Health Contract. For Questions please call 1-800-937-6824.
- 729 – This bill was reviewed in accordance with your First Health Contract. For Questions please call 1-800-937-6824.
- 767 – Reimbursed per O/P FG at 200%. Separate reimbursement for implantables (including certification) not requested per rule 134.403(G).

Explanation of benefits dated February 29, 2012

- CAC-193 – Original payment decision is being maintained upon review, it was determined that his claim was processed properly.
- 356 – This outpatient allowance was based on the medicare's methodology (Part B) Plus the Texas markup.
- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service.
- 728 - This bill was reviewed/denied in accordance with your First Health Contract. For Questions please call 1-800-937-6824.
- 767 – Reimbursed per O/P FG at 200% separate reimbursement for implantables (including certification) not requested per Rule 134.403(G).
- 891 – No additional payment after reconsideration.

Issues

1. Is the Requestor eligible for Medical Fee Dispute Resolution pursuant to 28 Texas Administrative Code §133.305 and §133.307?

Findings

1. This dispute was filed at the Texas Department of Insurance, Division of Workers' Compensation (Division), Medical Fee Dispute Resolution section on April 10, 2012 for resolution pursuant to 28 Texas Administrative Code §133.307.

   28 Texas Administrative Code §133.305 (a)(4) defines a Medical Fee Dispute as "A dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) that has been determined to be medically necessary and appropriate for the treatment of that employee's compensable injury." Non-network health care is defined in Section (a)(6) of the same rule as "Health care not delivered, or arranged by a certified workers' compensation health care network as defined in Insurance Code Chapter 1305 and related rules…" 28 Texas Administrative Code §133.307 (a)(1) similarly states that "This section applies to a request for medical fee dispute resolution for non-network or certain authorized out-of-network health care…" Therefore, pursuant to 28 Texas Administrative Code §133.307, the Divisions Medical Fee Dispute Resolution section may not address fee disputes involving health care delivered, or arranged by a certified network as defined by Insurance Code Chapter 1305, but may resolve disputes involving certain authorized out-of-network health care.

   Out-of-network health care is defined in Insurance Code Chapter 1305, section 1305.006 titled Insurance Carrier Liability for Out-of-Network Health Care. No documentation was found to support that the health care in dispute is authorized, out-of-network health care pursuant to Insurance Code Chapter 1305. Therefore, the dispute may not be resolved pursuant to 28 Texas Administrative Code §133.307, and Medical Fee Dispute Resolution is not the appropriate venue for resolution of the dispute filed by the requestor.

Conclusion

For the reasons stated above, the Division concludes that Medical Fee Dispute is not the appropriate venue for resolution of the issued raised by the requestor. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		8/1/12
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.
Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.